In order to request a hearing, the client or his legal representative shall submit a request in writing to the Department for Social Insurance office in the county of residence of the legal representative.

E. Application Appeal Procedures

If the application for AIS/MR services is denied by the Department for Medicaid Services, Division of Program Services staff, the client or legal representative shall receive written notification of the denial. Should the client or legal representative disagree with the denial of the application, the client has a right to a hearing with the Department for Social Insurance.

The client or his legal representative has up to forty (40) days from the date the denial notice is mailed to request a hearing. For the client currently in Medicaid payment status, if the hearing is requested within ten (10) days of the date of this notice, Medicaid benefits shall not be terminated before the hearing is held. The right to a hearing exists even if the client terminates services prior to requesting a hearing.

In order to request a hearing, the client or his legal representative shall submit a request in writing to the Department for Social Insurance office in the county of residence of the legal representative.

(1) The hearing is a formal proceeding meeting all due process standards.

(2) The client has the right to represent himself and retain legal counsel or other spokesperson during a hearing.

(3) The hearing is evidentiary, that is, the hearing decision is based solely on evidence presented at the hearing.

(4) The client or his legal representative may examine any documents to be used at the hearing both before and during the hearing.

(5) Adverse witnesses may be confronted and cross examined.

F. Criteria for Involuntary Termination and loss of AIS/MR Placement

An AIS/MR client shall be terminated from placement status and subsequently lose his placement in the following circumstances:

1) Clients or legal representative's failure to access required services, as specified in the client's Individual Habilitation Plan (IHP) and referenced on page 4.3, C. of this manual, for a period greater than ninety (90) consecutive days except for good cause shown;

2) Client's death;

3) Client's change of residence outside the Commonwealth of Kentucky;

4) Client elects to leave the program voluntarily as expressed by written notice of intent to discontinue given to the service provider and the DMS; provided however, that no action to terminate shall be taken until thirty (30) calendar days from the date of such notice has passed, within which time the client may reconsider and revoke his notice.

G. Termination Procedures

Based on the criteria stated above, and in accordance with 907 KAR 1:560, the client or his legal representative and the case management provider shall receive simultaneous notice of involuntary termination or intention to reallocate his placement at least ten (10) days prior to the effective date of the action.

Terminations initiated by the case management provider shall be submitted to the DMS at least twenty (20) days prior to the effective date of the termination. Subsequently, notice shall be issued by the DMS. The notice shall include a statement of the action being taken, the basis for the intended action, the authority by which the action is taken, and the client's right to appeal the determination within thirty (30) days of the notice of the action.

For the client currently in payment status, if the hearing is requested within ten (10) days of the date of the notice, Medicaid benefits shall continue through the end of the month of the hearing officer's decision.

Continued or reinstated benefits are considered overpayments if the agency decision is upheld. The right to a hearing exists, even if the client terminates services prior to requesting a hearing. See 907 KAR 1:560 for additional information on client rights.

SECTION VI - REIMBURSEMENT & BILLING INFORMATION

Reimbursement

A. Payment

To establish an initial reimbursement rate for AIS/MR services the provider shall submit a budgeted cost report. After the initial period, all providers shall submit actual costs for cost reporting.

Questions regarding the cost report shall be directed to the Division of Reimbursement at (502) 564-8196.

B. Billing Information

Billing information can be found in the AIS/MR Billing Instructions Packet. This packet explains how to complete a claim form, how to read remittance statements, how to contact the fiscal agent, information about third party coverage and recipient eligibility. Contact the fiscal agent for a copy of the Billing Instructions. See the Appendix for addresses and telephone numbers.

MAP-344 (Rev. 8/93)

KENTUCKY MEDICAID PROGRAM

Provider Information

1. _____ _____
(Name) (County)

2. _____
(Physical Location Address: Street, Route)

3. _____
(City) (State) (Zip Code)

4. _____
(Office Phone # of Provider) (Billing Office Phone # and Contact Person)

5. _____
(Pay to Address, if Different From Physical Location)

6. _____
(City) (State) (Zip Code)

7. _____ 8. _____
(Federal Employee I.D. #) (Social Security #)

9. _____ 10. _____ 11. _____
(License #) (Medicare #) (UPIN #)

12. _____ 13. _____
(Licensing Board) (Original License Date)

14. _____ 15. _____
(CLIA #) (Type of Certificate) (Attached)

16. Physician/Professional Specialty Certification Board:

_____

1st _____ Date _____

2nd _____ Date _____

Attach Copy of Board Certification.

17. Federal DEA # and Date Assigned: _____

18. Practice Organization/Structure:

_____ (1) Corporation
_____ (2) Partnership
_____ (3) Individual
_____ (4) Sole Proprietor
_____ (5) Public Service Corporation
_____ (6) Estate/Trust
_____ (7) Government/Non-Profit

19. If Corporation, list name and address of officers:

_____

_____

_____

_____

_____ _____
(Corporate Office Address) (Telephone #)

_____ _____ _____
(City) (State) (Zip Code)

20. If partnership, list name and address of partners:

_____

_____

_____

_____

21. If sole proprietor, give name, address, and phone number of owner:

_____

_____

_____

_____

_____

22. Control of Medical Facility:

_____ Federal _____ State _____ County _____ City
_____ Charitable or Religious _____ Proprietary (Privately-Owned)
_____ Other

23. If facility is government owned, list names and address of board members:

President/Chairman

_____

Member: _____

Member: _____

24. Distribution of beds in facility:

Acute Care _____ Psychiatric _____ Swing _____

Nursing _____ MR/DD _____

25. Fiscal Year End: _____

26. Administrator: _____ Phone #_____

27. Assistant Administrator: _____ Phone #_____

28. Controller: _____ Phone #_____

29. Accountant or CPA: _____ Phone #_____

30. Management Firm: _____

31. Lessor: _____

32. Has this application been completed as the result of a change of ownership or a change of tax ID number for a previously enrolled Kentucky Medicaid provider?

____Yes ____No

If yes give previous Kentucky Medicaid provider #: _____

33. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____ Date: _____

Name: _____

Title: _____

Return all enrollment forms, changes, and inquiries to:

Medicaid-Provider Enrollment
CHR Building, Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY

License Number Verified through _____ (Enter Code)

Comments:_____

_____

Date:_____ Staff:_____

MAP-343 (Rev. 5/86)

Provider Number: _____
(If Known)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19___, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

_____
(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

_____
(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

MAP-343 A
(11/91)

APPENDIX II

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

MAP-343B (8/93)

KENTUCKY MEDICAID PROGRAM

Disclosure of Ownership and Control Interest Statement
(Completion of this form is a mandatory participation requirement pursuant to 42 CFR 455.104.)

1. _____ _____
(Provider Name) (KY Medicaid Provider #)

2. _____
(Physical Location Address: Street, Route)

3. _____
(City) (State) (Zip Code)

4. List the name and address of each person or organization having direct or indirect ownership or control interest in the disclosing entity as defined by 42 CFR 455.101.

_____

_____

_____

_____

_____

5. List the name and address of each person with an ownership or control interest, as defined by 42 CFR 455.101, in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more.

_____

_____

_____

6. Are any of the individuals in items 4 and/or 5 related to one another as spouse, parent, child, or sibling (including step and adoptive relationships)?
__ YES __ NO

MAP-343B (8/93)
Page 2

7. If answer to #6 is yes, complete the following information.

Names	Relationship

8. List the name of any other disclosing entity in which person(s) listed in #5 have an ownership or control interest as defined by 42 CFR 455.101.

9. List the name of any individual or organization identified in item #4 who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII (Medicare), Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act.

10. List the name of any agent or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX of the Social Security Act.

WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIPATE OR IN TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104.

(Signature) (Date)

(Typed Name of Authorized Representative) (Title)

MAP-246 (Rev. 04/91)

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)

_____, to submit claims via electronic media for services provided to
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;

2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;

3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.

4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;

2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

_____
Signature, Authorized Agent of Billing Agency

Date:_____

Contact Name:_____

Telephone No.:_____

Software Vendor
and/or Billing Agency:_____

Media:_____

_____
Signature, Representative of the
Department for Medicaid Services

Date:_____

MAP-380 (Rev. 04/90)

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____, Name and Address of Provider hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a _____, _____ (Type of Provider and/or Level of Care) (Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

   A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.

   B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.

   C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

   "This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.

E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.

F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.

G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.

B. Agrees to assign to the provider or its agent a code to enable the media to be processed.

C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

BY:_____
Signature of Provider

Contact Name:_____

Title:_____

Date:_____

Telephone No.:_____

Software Vendor
and/or Billing Agency:_____

Media:_____

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY:_____
Signature of Authorized Official
or Designee

Name:_____

Title:_____

Date:_____

Instructions for Completion of MAP-246 and MAP-380

Complete the MAP-380 and MAP-246 only of you plan to file your Kentucky Medicaid claims electronically. The MAP-380 must be completed and signed by the provider, following these instructions.

1. Name and address of provider, as it appears in Kentucky Medicaid files.

2. Provider type, e.g., physician, dentist, etc.

3. Provider number (leave blank if submitting with your application).

4. Provider must sign form. Complete contact name, title, date, and telephone number as appropriate.

5. Circle software vendor (if you're doing your own billing) or billing agency and fill in name, as appropriate.

6. Media must be magnetic tape, 3.5 inch diskette, 5.25 inch diskette, Asynchronous PC modem, Synchronous 3780 mainframe, or Point of Service.

If you contract with a third-party billing agency, complete the MAP-380 and send it, along with a blank MAP-246, to the billing agency. A representative of the billing agency will complete the MAP-26 and send both the MAP-380 and the MAP-246 to:

Provider Enrollment
Department for Medicaid Services
3rd Floor East
275 East Main Street
Frankfort, KY 40621

If you have questions, please contact Provider Enrollment at (502) 564-3476.

ALTERNATIVE INTERMEDIATE SERVICES FOR THE MENTALLY RETARDED

STATEMENT OF SERVICES TO BE PROVIDED

AGENCY NAME: _____

ADDRESS: _____

_____

TELEPHONE NO: (___)_____

I/WE OF THE: _____
AGENCY

wish to provide the following services:
(check all that apply and indicate the specific services you will be providing in items 2, 3, and 7)

1. ___ Case Management Services
2. ___ Residential Services _____

_____

3. ___ Day Habilitation Services _____

_____

4. ___ In-Home Training Services
5. ___ Homemaker/Home Health Aide Services
6. ___ Personal Care Services
7. ___ Respite Services
8. ___ Habilitation Services _____

_____

I/We understand that in order to obtain a Kentucky Medicaid provider number, I/We must be so certified by the Division of Licensing and Regulation to provide each service checked in the blanks above.

_____
Print Name of Executive Director:

_____
Signature of Executive Director:

_____
Date:

AIS/MR CLIENT PLACEMENT FORM

Case Management Provider Name _____

Provider #_____ AIS/MR Effective Date _____

Client Identification:

1. Name_____
2. SSN _____
3. Medicaid # _____
4. Date of Birth _____
5. Legal Status _____

_____

6. Responsible Party _____

_____

In-Home Services:

9. Date: _____
10. Home Address: _____

_____

_____

_____

Phone: ( ) _____

Core Placement:

7. Date:_____
8. Core Location: _____

_____

_____

Residential Placement:

11. Date: _____
12. Name of Residential Contractor:

_____

Address: _____

_____

Phone: ( ) _____

_____

_____

13. Facility Name _____
Admission Date _____ Discharge Date _____

Reason:

_____

_____

_____

14. Termination Date: _____ Reason: _____

_____

15. Submitted by/Title: _____

16. Today's Date: _____

Instructions for Completing Client Placement Form

(Please print or type the information)

Enter the information in the top section as follows:

-Case Management Provider Name

-Case Management Provider Number

-AIS/MR Effective Date - This is the date the client actually began receiving AIS/MR services.

Client Identification:

1. Enter client's name: last name, first name, middle initial.
2. Enter Social Security Number.
3. Enter Medicaid Number.
4. Enter client's date of birth: month/day/year.
5. Enter client's legal status.
6. Enter client's responsible party.

Core Placement:

7. Enter the date the client entered the core residence.
8. Enter the address of the core location.

In-Home Services:

9. Enter the date the client began receiving in-home services.
10. Enter the client's home address and telephone number

Residential Placement:

11. Enter the date the client was placed in a residential placement.
12. Enter the name, address, and telephone number of the residential placement provider.

Complete the remainder of form as indicated.

13. Enter the name of the facility where the client was placed. Enter the admission and discharge date. Enter the reason the client was placed in the facility. Facility includes ICF/MR/DD placement and acute care hospital placement.
14. Enter the date the client was terminated from the AIS/MR program. Enter the reason the client was terminated.
15. The person completing the form, usually the case manager, must sign the form and enter his title.
16. Enter the date the form was completed.

MAP-350 (Rev. 1/92)

LONG TERM CARE FACILITY (NF or ICF/MR/DD)
ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
HOME- AND COMMUNITY-BASED SERVICES
KENTUCKY MEDICAID PROGRAM CERTIFICATION FORM

I. RECIPIENT INFORMATION

Medicaid Recipient's Name _____

Medical Assistance Identification Number _____

Address of Recipient _____

_____ Phone _____

Responsible Party/Legal Representative _____

Address _____ Phone _____

II. HOME- AND COMMUNITY-BASED WAIVER SERVICES FOR THE AGED & DISABLED (HCBS) or ALTERNATIVE INTERMEDIATE WAIVER SERVICES FOR THE MENTALLY RETARDED (AIS/MR) CERTIFICATION

A. HCBS (Waiver for the aged & disabled) - This is to certify that I/legal representative have been informed of the HCBS Waiver. Consideration for the HCBS program as an alternative to NF placement is requested /_/; is not requested /_/.

_____ _____
Signature Date

B. AIS/MR (Waiver for mentally retarded/developmentally disabled) - This is to certify that I/legal representative have been informed of the AIS/MR program. Consideration for the AIS/MR program as an alternative to ICF/MR/DD placement is requested /_/; is not requested /_/.

_____ _____
Signature Date

III. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Social Insurance.

_____ _____
Signature Date

Signature and Title of Person Assisting _____

with Completion of Form _____

Agency/Facility _____

Address _____

CODE OF FEDERAL REGULATIONS 483.430

Health Care Financing Administration

"Qualified mental retardation professional" means a person who has at least 1 year of experience working with persons with mental retardation or other developmental disabilities and is one of the following:

1. A licensed doctor of medicine or osteopathy.

2. A registered nurse.

3. An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b) (5) which designates professional program staff, including an occupational therapist who is

(i) eligible for certification as an occupational therapist by the American Occupational Therapy Association, or a comparable body ;or

(ii) an occupational therapy aide who is eligible for certification as an occupational therapy assistant by the American Occupational Association or a comparable body; or

(iii) a physical therapy aide who is eligible as a physical therapist by the American Physical Therapy Association or a comparable body; or

(iv) a physical therapy aide who is eligible for registration by the American Physical Therapy Association or is a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body; or

(v) a psychologist who has at least a master's degree in psychology from an accredited school; or

(vi) a social worker who holds a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body; or

(vii) a speech-language pathologist or audiologist who is eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body, or meets the educational requirements for certification and be in the process of accumulating the supervised experience required for certification; or

(viii) a professional recreation staff member who has a bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education; or

(ix) a professional dietitian who is eligible for registration by the American Dietetics Association; or

(x) a human services professional who has at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

INCIDENT REPORT

Region _____ Date of Incident: _____

Name of client: _____ M.A.I.D.#: _____

Name of staff making report: _____ Time of incident: _____

Signature of staff making report: _____ Signature of supervisor: _____

Department/program services: _____

Agency: _____

Type of incident (check one or more)

Medical

___ Injury of client
___ Injury of staff
___ Contagious disease
___ Medical emergency room
___ or hospitalization
___ Medication problems
___ Seizure

Social/Legal

___ Legal problem (client victim)
police involvement
___ Client suspected offender
___ Client missing
___ Severe behavior problem
___ Property damage
___ Suspected or known neglect or abuse
___ Abuse by family

OTHER

___ Execessive absenteeism
___ Unauthorized client move
___ Possible violation of client rights
___ Other

Notified of incident (please check)
___ Parent
___ Legal Representative
___ Protective Services

Describe Incident: (what happened, how, where, how was situation handled, who was involved, why)

_____

_____

_____

_____

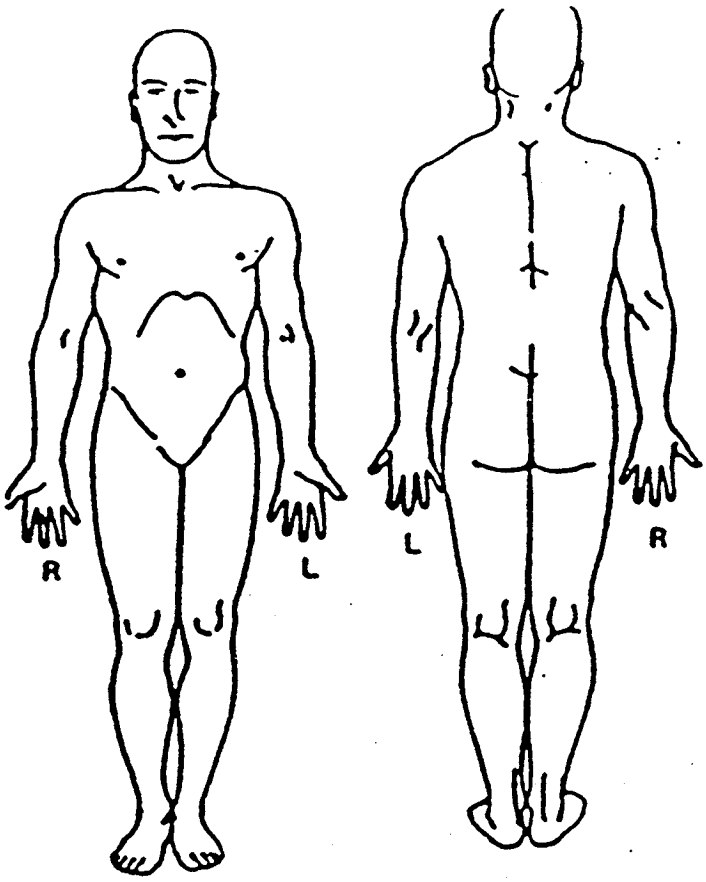
_____

_____

Has this particular or similar incident occured before? YES ___ NO ___
If yes, give date. _____
If incident involved personal injury to client or other, complete the following:

Name of Person: _____

APPENDIX IX



Use red ink to mark on figures any bruises, cuts, scratches, marks, etc., as soon as discovered.

Name and address of physician and/or hospital: _____

_____

Treatment given: _____

_____

_____

_____

Follow-up needed: _____

_____

_____

Describe action taken results, disposition: _____

_____

_____

_____

Investigation Report: _____

_____

_____

Signature and Position Title: _____

Reviewed by cluster manager: _____ Date: _____

Reviewed by MR/DD Director: _____ Date: _____

Describe follow-up plan or recommendation: _____

_____

_____

_____

_____

Complete and mail the form to: Director, Division of Mental Retardation, Department for Mental Health/Mental Retardation Services, 275 East Main Street, Frankfort, Kentucky 40621.

Involuntary Termination Report

Region: _____ Date: _____

Client Name: _____

Medicaid # _____ Date AIS/MR services began: _____

AIS/MR services provided: _____

_____

_____

Reason for considering termination: _____

_____

_____

_____

Action taken to help prevent termination: _____

_____

_____

_____

_____

Services to be provided after termination: _____

_____

_____

_____

_____

People involved in considering termination: _____

_____

_____

_____

_____

Believing that every individual is entitled to the least restrictive living arrangements possible, we have been impressed with the concepts and goals set forth by AIS/MR Program. By giving our clients the opportunity to participate in a program which provides the most appropriate living situation possible, with specific support services enlisted in advance to meet the needs of every individual, we realize that our task will be made easier and life will be more meaningful for our clients.

Guardianship staff recognize that clients participating in AIS/MR receive individualized attention and therefore assume that it is not necessary to provide the same level of support services that are provided to other wards. However, it is important that AIS/MR staff realize that our legal status and responsibilities do not change when a client becomes an AIS/MR project participant. Even though the Program Coordinator, Center Directors, Core Staff, and ALU Providers all play a most important role in the lives of our clients, the Guardianship Agent continues to have ultimate responsibility in ensuring the health and well-being of the individual for who the Cabinet serves as legal guardian.

If the Guardianship Agent is to fulfill the duties designated by law, an effective system of communication must be established and maintained between the Agent and the care provider. We expect the care provider to assume the following responsibilities:

1. Provision of appropriated care, supervision, and appropriate support services.

2. To notify the Guardianship Agent of significant health care needs or changes in the physical or mental condition of the client. Through a phone call, notify the guardian of significant changes (for better or worse) in the health condition of the client. Follow-up with a written statement. Routine health care does not require reporting unless provided at a facility that requires a signature for treatment.

3. To contact the Agent to secure prior permission for medical treatment or services as needed. Permission to sign for medical release can be given to a program staff person. This should be arranged on a client by client basis. Notice of treatment, whether emergency or just variance from routine, is still required. The Permission for Emergency and Limited Medical Treatment Form is attached.

4. Maintain financial and other pertinent records.

5. To communicate to the Agent any special needs of the client such as clothing, personal items, recreational or medical supplies.

6. To inform the Agent prior to any change in client status, such as living arrangements, level of care, or change of address. All decisions pertaining to changes in the living situation of the client will be made by the Guardianship Agent, except in an emergency situation where relocation is necessary to preserve the health and well-being of the client and notification of the Agent is not possible. In such event notice will be given to the Agent as soon as possible.

The Guardianship Financial Agent is responsible for the management of the client's financial benefits. Their responsibility includes the disbursement of payment to the Comprehensive Care Center, the paying of bill incurred by the client, the investment of the client's excess funds, and establishing burial accounts. One of their most important responsibilities is maintaining the client's eligibility for benefits. For this reason, the Agent must maintain strict control over financial matters, and have access to all information pertaining to client status (living arrangements, level of care, admission and discharges from hospitals) which has an affect on such eligibility.

A portion of wages earned by SSI recipients is considered in determining SSI eligibility. Because AIS/MR participants and involved in work programs and receive wages, their eligibility for SSI can be affected. Therefore, wages must be reported and a form is attached to simplify this process. This form must arrive in the Fiduciary Office by the 10th of each month and should report wages earned the previous month. No matter how small the wages, even no wages for that month, must be reported. Failure to report may lead to a requirement that all wages be forwarded to the Fiduciary Office and the participant would not benefit from the experience of receiving their own check. Continued failure to report, or to submit the check if that were required, can lead to loss of SSI and Medicaid eligibility, in turn loss of monthly expense payment to your agency. This report is extremely important and timely submittal of the form is expected.

In addition to monthly wages, clients personal funds have a significant bearing on hi/her eligibility for benefit programs. It is possible that the total of personal funds held on behalf of the AIS/MR participant by the Comprehensive Care Center and the client's funds held by Guardianship could exceed the maximum income limits for SSI or Medicaid benefits. Medicaid and SSI have strict eligibility requirements. Clients who exceed the income requirements are terminated immediately from the benefit program. If the client is found to be ineligible after benefits are paid, the entitlement agency may demand a refund beginning from the date of ineligibility. Thus, it is of utmost importance that the Guardianship office maintain a strict accountability over the client's funds. Therefore, the monthly wage reporting form has been modified to include a space for reporting the personal funds. We do request that the client's

account held by the center not exceed $200.00. Any funds in excess of $200.00 should be refunded to the Guardianship office. We also ask that no insurance policies, savings accounts, or other liquid assets be established by anyone other than the Guardianship Agent.

COURT REPORT

The guardian is also mandated by law to file an annual report with the court stating the client's current mental, physical, and social condition, the address of every residence of the client during the reporting period (one year), length of stay at each residence, a summary of the medical, social, educational, vocational, and other professional services received by the client, the outline of the guardian's visits and activities on behalf of the client as often as possible and to subsequently file a report with the court annually.

The responsibility to work closely with the state Guardianship staff only applies to clients who the state has been assigned as Agent. There are persons who have been declared disabled for whom the family or other party has been assigned Agent. Those guardians have the same responsibilities and similar arrangements should be made with them.

Appendix XI rev 1/92

EMERGENCY MEDICAL PROCEDURE AND PERMISSION FORM

I hereby grant permission for _____ to receive emergency treatment with the following exceptions:

Admisssion to acute care medical facility
Psychiatric admission
Surgery.

In the event _____ requires admission to an acute care facility, medical or psychiatric, permission from the guardianship agent and/or field worker must be secured. If neither the agent or field worker is available for consent, emergency treatment necessary to maintain the health of _____ is granted and notification of such treatment must be reported within 12 hours to the agent/ field worker.

These requirements are in accordance with the statutes of KRS 387.660 Paragraph 3.

Routine medical and dental care and administration of medications and therapies as prescribed by the physician are pre-authorized by the agent on behalf of _____.

Helen Cleavinger
CHR AGENT

PHONE# (work) 502-564-2474
(home) 502-425-8320

_____
Field Worker

PHONE# (work) _____
(home) _____

Jan 2, 1992
Date

Helen K. Cleavinger
AGENT'S SIGNATURE

#10

Appendix XI

CONSENT TO TREATMENT

I, Helen K. Cleavinger, Agent, Cabinet for Human Resources, do hereby give my consent for the following treatment to be provided to _____, ward:

1. General medical and dental treatment as outlined on the Emergency Medical Procedure and Treatment Form (rev.1/92) excluding however the administration of psychotropic medications. If continued or repeated dosages of psychotropic medications are deemed beneficial to the ward, the physician should contact me directly for specific approval of such medications.

2. Participation in Daily Habilitation programming, Planned Recreational Activities, Ancillary Services, Case Management and Respite Care.

3. Placement in an Alternate Living Unit (ALU), provided, however, that the Guardianship Agent has had adequate opportunity to review, inspect and approve the ALU BEFORE placement. For purposes of this section, fourteen (14) days notice shall be deemed an adequate opportunity.

4. the following additional services: _____

_____

_____

_____

On behalf of the ward, I request that you notify the Guardianship Agent or Field Worker of all changes in the ward's status including change in living arrangements, level of care, change of address, medical status, or behavior status. Please contact me at (work) telephone number (502) 564-2474 or (home) telephone number (502) 425-8320. The guardianship Field Worker assigned to you is _____ Their work phone number is _____ and home is _____.

Please be advised that in order to maintain the ward's eligibility for benefits, a monthly wage and personal funds report must be submitted by the 10th of the following month. The ward's personal funds should not exceed $100. In addition, no insurance policies, savings accounts or other liquid assets may be established on behalf of the ward by anyone other than the Guardianship Agent.

Date Jan 2, 1992

Helen K Cleavinger

Helen Cleavinger, Cabinet for Human Resources, Agent

Date Submitted: ____________________ Person Submitting: ________________

Region: ________________________ Reporting Month: ____________________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: __________________________ Social Security Number: ______________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

(OVER)

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Name: ______________________ Social Security Number: ____________
Wages Earned: __________ Work Station: __________ Personal Funds: __________

Mail To:

Fiduciary Supervisor
1st Floor East
CHR Building
275 East Main Street
Frankfort, Kentucky 40621

STEP-BY-STEP INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL HABILITATION PLAN (IHP)

General instructions:

This document is intended to be a working individual plan. It should be kept current so that it accurately reflects any modifications made. The plan should be done annually with at least six-month reviews. Specific objectives, however, may be reviewed and revised at other intervals. This packet is also put together in the order in which decisions should be made so that there is a smooth, logical flow from one section to the next.

Additional information is required by the various funding sources. There may be an additional page needed for various funding agents (e.g., DCP, AIS/MR, DDPC, etc.). The instructions include specific requirements for the various funding sources.

The individual and the family/guardian, if appropriate, should receive a copy of the Plan. For DCP, this must happen.

For services funded by the Developmental Disabilities Planning Council (e.g., Special Services and Equipment), the following IHP pages need to be submitted along with the DD Certification:

Pgs. 1, 2, 7, 8.

For services funded by the Disabled Children's Program, the following documents need to be submitted with the IHP:

D-63 - SSI DCP Service Provider Form

D-98 - Agreement to Participate in SSI / DCP and Authorization for Release of Information

Social History

When indicated the following forms must also be submitted:

D-142 - DCP Adaptive Equipment Inventory/Transfer Form

D-61 - DCP Parent Contract for Adaptive Equipment

D-145 - SSI/DCP Justification/Recommendation for Adaptive Equipment, Educational Material, Medical Equipment/Supplies

The IHP must be done annually

For AIS / MR services, the Cost Worksheet must also be submitted.

Human Rights Committee: An agency's Human Rights Committee is a duly constituted body of individuals whose purpose is to ensure that an individual's rights are protected and supported. Its role is to review at least annually those restrictive procedures which may be practiced by the agency, either in the form of behavioral interventions, or basic rights (legal, civil, human) restrictions. Committee membership should include consumers, their representatives, and others not affiliated with the agency. The committee should ensure that informed consent has been secured for any restrictions.

Service Objectives: Service objectives are short-range or ongoing outcomes that describe the individual's movement or status change as an outcome of support services. Such objectives cannot be achieved as a result of learning or training and may include:

1. outcomes related to enhancing community integration or developing and maintaining social relationships, or
2. outcomes dependent on staff, such as provision of adaptive or mobility orthotic or prosthetic equipment, use of mechanical supports for body position/balance, modified diets, weight control, seizure disorders, obtaining specialized assessments, obtaining job opportunities in community businesses, or securing the environmental changes and social supports necessary to promote the successful functioning of the individual in the community.

Strengths and Needs: Strengths and needs are usually determined through the assessment process. Strengths are based on the personal resources of the individual or family.Developmental strengths and needs should be "specific" - use terms that are observable and as measurable as possible and that describe what an individual can and cannot do. Do not use non-specific terms such as "good - skills", "poor --- ability" or age/grade levels.

Non-developmental needs may also be specified in the listing. These are usually services the individual/family needs that are provided by someone else. These usually will then result in a service objective. Example: prevention of further contractures, adequate housing space, pureed diet of 1500 calories.

INDIVIDUAL HABILITATION PLAN APPENDIX XII

1 Name _____ 2 Date of Plan _____

3 Identifying #(s) _____ 4 Date of Birth _____ 5 In-Home ___ Residential ___

6 Case Manager _____ Phone _____

7 Client Address(Current) _____

_____ County _____ Region _____

Cluster _____

8 Parent's Name & Address _____ Provider # _____

_____ phone _____

9 Legal Status _____

Legal Rep.'s Name & Address _____

_____

_____

10 Date of Admission to System _____

11 Date of Admission to AIS/MR _____

12 Date of Annual IHP _____

13 POC Effective Date _____

14 DSM III -R Diagnoses & Codes

Axis I _____

Axis II _____

Axis III _____

_____

Axis IV _____

Axis V _____

15 Services / location / provider | Frequency/Duration

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

16 Current Medications

_____

_____

_____

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

_____

_____

_____

TRANSMITTAL #10

Name _____ ID# _____ Date _____

INTERDISCIPLINARY TEAM MEMBERS (the following individuals had input into the development of this IHP

17 Signature denotes presence):	18	19	20
Signature of Those Present	Identified Team Members	Title/Relationship	Agency
		Client	
		Case Mgr.	

21 Required signatures for persons who did not attend the team meeting:

STRENGTHS AND NEEDS

22 Strengths

23 Needs

24 Positive reinforcers

25 DISCUSSION :

Name _____ ID# _____ Date _____

26 SUMMARY OF MEDICAL HISTORY / CHANGES IN THE PAST YEAR:

EVALUATION OF CURRENT ENVIRONMENT: Do the social and physical aspects of the living, working, and training environments provide more supervision and intrusion than the individual needs? Does the individual like those with whom he/she lives or works? Are the relationships positive ones? Do physical adaptations need to be made to accommodate the individual and assist in greater independence?

27 PREFERENCES OF INDIVIDUAL/FAMILY FOR SERVICE DELIVERY:

28 PLAN FOR ACHIEVING ENVIRONMENTAL CHANGE:

Name _____ ID# _____ Date _____

GUARDIANSHIP / ADVOCACY:

Indicate whether individual wants or needs:

Guardianship: ( )Yes ( )No

Advocate: ( )Yes ( )No

If the answer is "yes" to either of the above, provide specific information as to wants or needs of the individual and develop a service objective. If there is any difference of opinion between team members (including individual and family) explain.

29 CITIZENSHIP / SELF ADVOCACY:

Does individual want or need training in the rights and responsibilities of citizenship?

If yes, incorporate the plan into behavioral / service objectives.

If no, why not ? _____

_____

_____

Does the individual want or need training in self advocacy? _____

If yes, incorporate in a behavioral / service objective.

If no, why not ? _____

_____

_____

Name _____ ID# _____ Date _____

RIGHTS RESTRICTION: (includes purchasing own clothing, access to personal possessions, freedom of movement, access to telephone/mail, access to own money/checking account, cigarettes, participation in religious activities,etc.)

Use the format below to note any rights restrictions:

Restriction & Rationale _____

_____

_____

Action / Training to Reduce _____

_____

30 Due process procedure: Consent _____ HRC _____

Date _____ Date _____

31 Outcomes: _____

32 Review Date: _____

_____

Restriction & Rationale _____

_____

_____

Action / Training to Reduce _____

_____

Due process procedure: Consent _____ HRC _____

Date _____ Date _____

Outcomes: _____

Review Date: _____

_____

Restriction & Rationale _____

_____

_____

Action / Training to Reduce _____

_____

Due process procedure: Consent _____ HRC _____

Date _____ Date _____

Outcomes: _____

Review Date: _____

_____

USE AS MANY PAGES AS NECESSARY TO COVER ALL RIGHTS RESTRICTIONS

Name _____ ID# _____ Date _____

33 BEHAVIOR INTERVENTION:

Does the individual need a behavior intervention plan? ( )Yes ( )No

Does the individual have a behavior intervention plan? ( )Yes ( )No

If so was a functional analysis done prior to the development of the plan? _____

Next review date of the behavior intervention plan:

by the Team _____ by the BIC _____ by the HRC _____

Outcomes of above reviews: _____

_____

Does the plan need to be revised? ( )Yes ( )No

If yes, specify: _____

_____

_____

Is the individual on any medications for behavior control? ( )Yes ( )No

If yes, what is the plan for medication reduction? _____

_____

_____

Complete the following if physical restraint (manual as well as mechanical), drugs for behavior intervention, "time-out", or other intrusive technique are used; present the justification that potentially harmful effects of the behavior outweigh the potentially harmful effects of the procedure:

_____

_____

_____

_____

_____

What less intrusive techniques have been tried?

_____

_____

_____

Name _____ ID# _____ Date _____

GOALS AND OBJECTIVES

GOAL # ___ _____

_____

Behavioral Objective # ___ _____ 34

_____ 35

_____ 36

_____ 37

_____ 38

_____ 39

Responsible Person _____
Agency/Service _____
Frequency _____
Start Date _____
Est. Compl. Date _____
Actual Compl. Date _____

40 Reviews

Date: _____

_____

_____

Date: _____

_____

Behavioral Objective # ___ _____

_____

_____

_____

Responsible Person _____
Agency /Service _____
Frequency _____
Start Date _____
Est. Compl. Date _____
Actual Compl. Date _____

Reviews

Date: _____

_____

_____

Date: _____

_____

Behavioral Objective # ___ _____

_____

_____

_____

ResponsiblePerson _____
Agency /Service _____
Frequency _____
Start Date _____
Est. Compl. Date _____
Actual Compl. Date _____

Reviews

Date: _____

_____

_____

Date: _____

_____

_____

USE AS MANY PAGES AS NECESSARY TO COVER ALL GOALS AND OBJECTIVES

Name _____ Identifying # _____ Date _____

APPENDIX XII

SERVICE OBJECTIVES

43

41 DATE	SERVICE OBJECTIVE	42 METHOD	PERSON / AGENCY RESPONSIBLE	COMPLETION/ REVIEW DATE

USE AS MANY PAGES AS NECESSARY TO COVER ALL GOALS AND OBJECTIVES

TRANSMITTAL #10

Name _____ ID# _____ Date _____

4 4 TEAM CONSENSUS

Name _____ ID# _____ Date _____

APPENDIX XII

ASSESSMENT AND EVALUATION INFORMATION

ASSESSMENT CHECKLIST (*Optional*):

45

		COMMENTS: RECOMMENDATIONS/ LOCATION / ASSESSOR	DATE OF ASSESSMENT	DATE OF NEXT ASSESSMENT
HEALTH CARE ASSM.	___ Physical/Medical Examination ___ Current Medical Status ___ Dental Examination and Evaluation ___ Auditory Screening ___ Visual Screening ___ Nutritional ___ Other _____			
SOCIAL ASSM.	___ Social Evaluation Date ___ Financial Information ___ Legal Info. and Guardianship Status ___ Other _____			
PSYCH ASSM.	___ Standardized Test of Intell. Fcng. ___ Fcn. Analysis of Maladaptive Behaviors ___ Other _____			
EDUC/ VOC. ASSM.	___ Educational ___ Vocational ___ Other _____			
SPEECH & LANG. ASSM.	___ Expressive Speech & Lang. ___ Receptive Speech & Lang. ___ Other _____			
DEVELOP-MENTAL ASSM.	___ Adaptive Behavior Evaluation or ___ Independent Living Skills Assessment ___ Other _____			
ADD. SPEC. ASSM.	___ Occupational Therapy ___ Physical Therapy ___ Recreational Therapy ___ Music Therapy ___ Other _____ ___ Other _____ ___ Other _____ ___ Other _____			

DMR-001 dates

COST WORKSHEET

Recipient's Name _____ Date of IHP _____

Medicaid # _____ Date of Addendum _____

WAIVER SERVICES	UNITS PER WEEK	COST PER UNIT	COST PER WEEK (COL.A X B)	TOTAL COST MONTHLY (4.3 XCol.C)
	A	B	C	D

COST PER MONTH $_____

Instructions:

1. Complete requested information at top of page. (If not an addendum, write NA in that blank).
2. Identify waiver service.
   A. Units per week of requested service
   B. Cost per unit of service
   C. Column A multiplied by Column B
   D. Column C multiplied by 4.3
3. Cost per month = Cost of Column D totaled

MAP-95
(Rev. 04-88)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

REQUEST FOR EQUIPMENT FORM

RECIPIENT'S NAME _____ MAID # _____ BIRTHDATE _____
Mo Day Yr

List Other Insurance Coverage _____

Estimated Time Needed # _____ Months _____ Indefinitely _____ Permanently

Specific Equipment Item Requested: Please include Medicare codes for parts to items such as Braces, Prostheses, and Wheelchairs (if applicable). Otherwise, group parts together under Code E1399 or appropriate miscellaneous code for braces/prostheses.

—PURCHASE:

Item	Code	Manufacturer's Suggested List Price (IC Items Only)	Agency's Acquisition Cost (All Items)

Trade Name/Model Number of Equipment Item (if applicable) _____

_____

Manufacturer's Name _____

RENTAL:

If Rental is Requested, Please Specify Amount $_____

Supplier of Equipment _____

Address _____

Date of Delivery if Equipment Item is Already Placed in Home - Date _____

Agency Name _____ Provider # _____

Authorized Signature _____

APPLICATION FOR AIS/MR/DD SERVICES

Name of Applicant _____
Last Middle First

Social Security Number _____

Present Address _____

_____
City County State Zip Code

Phone _____

Legal Rep. (if applicable) _____

Address _____

_____

Phone _____ Relationship to Applicant _____

2. Case Management Provider Name & Address, if applicable

Name _____

Address _____

_____
City County State Zip Code

_____ _____
Applicant Signature Date Legal Rep. (if Applicable) Date

==========

This section to be completed by physician.

1. Axis II diagnosis: Mental Retardation _____

Developmental Disability _____

2. _____ has demonstrated a need for
(Applicant Name)
active treatment and would benefit from active treatment in the AIS/MR/DD Program.

_____
Physician Signature Date

MEDICAID PROGRAM FISCAL AGENT INFORMATION

The Kentucky Department for Medicaid Services' fiscal agent, effective December 1, 1995, shall be the Unisys Corporation. Unisys can be reached as follows:

UNISYS CORPORATION ADDRESSESS

Accident & Work Related Claims
Post Office Box 2107
Frankfort, KY 40602

Adjustments & Claims Credits
Post Office Box 2108
Frankfort, KY 40602

Cash Refund
Post Office Box 2108
Frankfort, KY 40602

Claims Submission
Post Office Box 2101
Frankfort, KY 40602

Prior Authorization
P.O. Box 2103
Frankfort, KY 40602

Provider Relations (Inquiries)
Post Office Box 2100
Frankfort, KY 40602

Third Party Liability
Post Office Box 2107
Frankfort, KY 40602

Electronic Claims Submission
Post Office Box 2016
Frankfort, KY 40602

Unisys Corporation Telephone Numbers:

Kentucky		Out-of-State	
Drug Prior Authorization:	800-807-1273	Drug Prior Authorization:	502-226-1140
Electronic Claims:	800-205-4696	Electronic Claims:	502-226-1140
Provider Relations:	800-807-1232	Provider Relations:	502-226-1140

Automated Voice Response System:
Claims Status Inquiries: 800-807-1301
KenPAC Eligibility: 800-807-1301
Third Party Liability Eligibility: 800-807-1301

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